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SUBJECT: HEALTH CARE IN BOTSWANA IN THE ERA OF HIV/AIDS

¶1. Summary: Botswana just celebrated its National Day on September 30 and the country has made significant progress in the fight against hunger, poverty, injustice, illiteracy and unemployment over the last forty two years. The rate of progress is, however, threatened by the HIV/AIDS epidemic, and could be reversed in the absence of a concerted national fight against the epidemic. The HIV/AIDS epidemic has also imposed a considerable burden on the public health system. Concerns have been expressed that HIV/AIDS programs, especially the, ART treatment program, have squeezed the resources available for other important health needs and programs. End Summary.

Background

¶2. Botswana has made significant progress in the fight against hunger, poverty, injustice illiteracy and unemployment over the last forty two years. The country rose from being one of the poorest in the world at the time of independence, to becoming a middle-income, developing nation. Nonetheless, this progress is now threatened by the HIV/AIDS scourge, and could be reversed in the absence of a concerted national fight against the epidemic. Botswana is one of the countries hardest hit by HIV/AIDS epidemic. The Botswana AIDS Impact Survey of 2004 estimated HIV prevalence in the general population at 17.1 percent. The prevalence rate among pregnant women aged 15- 49 years was 32.4 percent, with Chobe district having the highest rate (42 percent) and Kgalagadi the lowest (19.1 percent). The HIV/AIDS epidemic has also imposed a considerable burden on the public health system such as: a) an increase in the number of patients being treated for HIV/AIDS-related illnesses and their social impacts; b) a rise in the death rate; c) a reduction in the population growth rate and life expectancy; and d) a substantial increase in the number of orphans and vulnerable children (OVC). This is having adverse implications for the health and other development sectors. Furthermore, Botswana's health infrastructure, despite efforts made by the government of Botswana (GOB) and development partners, continues to perform insufficiently in granting access, equity, quality, effectiveness, efficiency and sustainability in health care delivery. The health system thus continues to bear the brunt of the impact of the HIV/AIDS pandemic.

¶3. Significant, however, is the government's deep commitment to high levels of expenditure on meeting the basic needs of the population. Since the mid-1970s, 30-40 percent of the annual budget has been allocated to the social sector. Government health facilities provide primary health care and top-level hospital treatment free, including anti-retroviral treatment (ART) for only a token payment. Providing communities with safe drinking water is another high priority for the GOB. Much of this additional expenditure has been directed to HIV and AIDS, and there are concerns that this has caused a diversion of health resources away from other health needs. This remains a major worry among some health practitioners, who have expressed fears that the focus on HIV/AIDS has allowed other equally dangerous diseases such as cancer, hypertension, diabetes and diarrhea to ravage populations unabated and unnoticed. (Note: A long article in the Botswana Gazette edition of 20-26 February 2008, titled "Health System Hobbled by Focus on HIV and AIDS" spelled out these concerns in sobering detail. End Note).

Health challenges

¶4. Botswana still faces major health challenges in managing other

diseases such as cancer, diabetes, diarrhea, high blood pressure and others as listed below. A concerted effort by the GOB, development partners and civil society is needed in order to focus attention on these diseases and on the improvement of health care service delivery.

¶5. Tuberculosis (TB): TB is often associated with HIV and AIDS as one of the main opportunistic infections in those who are HIV positive. After many years of decline, TB notifications started rising in the early 1990s and increased from 200 per 100,000 people in 1990 to 620 per 100,000 in 2002; and by 2007, approximately 80 percent of patients were co-infected with HIV. TB prevalence in Botswana is thus now one of the highest globally. Moreover, TB drug resistance is a challenge: there are multi-drug resistant TB (MDRTB), and extensively drug resistant TB (XDRTB) manifesting themselves in patients. MDRTB refers to resistance against first-line drugs-isoniazid and rifampicin. XDR indicates a resistance to almost all of the effective anti TB drugs. One hundred cases of MDRTB have been identified and put on treatment in Botswana. There were two cases of XDRTB that were recorded and the patients put on treatment, but one died. According to a Ministry of Health (MOH) 2006 assessment, MOH 2005 data also reports significant progress in immunizing against TB, with BCG immunization coverage reaching 99 percent. Additionally, health facility reports of March 2007 indicate coverage of 88 percent, according to MOH statistics from the Child Health Unit.

¶6. A number of initiatives have been put in place such as: i) isoniazid TB preventative therapy (IPT) for people living with HIV and AIDS; ii) the establishment of improved TB diagnostic capacity with the development of a TB reference laboratory with drug resistance capacity; and iii) the strengthening of TB surveillance capacity through the development and implementation of a national computerized TB transmission in health care facilities. However, efforts still need to be intensified in order to reach 100 percent coverage. Botswana has made commendable progress in making TB treatment accessible, attaining adequate case identification through an electronic TB register, keeping resistance below 1 percent and maintaining an effective DOT strategy and community mobilization. All of these efforts and results demonstrate positive progress towards reducing morbidity and mortality caused byTB.

¶7. Malaria: The occurrence of malaria in Boswana is seasonal, and is related to rainfall peiods. The number of cases thus varied between 202 and 2006. Botswana recorded 3,453 confirmed cases in 2004, but only 53 confirmed cases in 2005, a record low. A Malaria Indicator Survey (MIS) conducted in March, 2007 rvealed that the current level of malaria control in Botswana needs to be pushed to a new frontier, with the current IRS coverage of 67.6 percent; this needs to rise to above 80 percent. In addition, vector control through Insecticide Treated Nets (ITNs) was identified as an area that needs improvement. The survey showed levels of 26 percent ITNs coverage at household level, with 15.4 percent for pregnant women and 12.9 percent for children under five. In order to attain this target, an increased coverage of prevention measures over and above those currently used will be necessary. The house-to-house community education initiatives, such as the one carried out last August by students and teachers of the Gaborone Senior Secondary school and Alexander Dawson School, Colorado, in collaboration with the U.S. Embassy, are commendable examples of this extra effort.

¶8. Maternal and Reproductive Health: For a number of years, the percentage of women availing themselves of the antenatal services have been over 90 percent. In addition, more than 90 percent of deliveries are conducted by skilled health practitioners. The Sexual and Reproductive Health Program incorporates a strong component of IEC and Safe Motherhood Initiative (SMI) elements. Moreover, family planning was designed to improve maternal health in Botswana. Data on maternal mortality is poor, with various estimates of the maternal mortality ratio (MMR) from different sources. For instance, government health facilities data for 2005/2006 indicates a rate of 150 per 100,000 live births, a marked improvement from the 330 rate in the 1991 census. The establishment of a Maternal Mortality Audit System, which is focused on collecting facility based data on maternal deaths, is a development that will also indirectly address issues of quality of services and inefficiency.

¶9. According to the joint March 2007 IATT draft report, existing opportunities to optimize access to HIV infected women to family planning have not been fully explored. Data from surveys in Gaborone and Francistown revealed that 65 percent of pregnancies among HIV positive and negative women were unplanned and 35 percent unwanted. Additionally, although CD4 testing is available to pregnant women, the proportion of HIV-infected pregnant women accessing ARV therapy for their own health is lower (16 percent) than the target of 25 percent. Given the policies, frameworks and strategies towards maternal health that have been put in place, the GOB has made significant strides in improving this sector. However, there are major gaps in the ability of health institutions to deliver, both in terms of the health systems, resources, supplies and equipment, as well as sufficient staff with the requisite knowledge and skills. Family planning needs to be integrated with the Prevention of Mother To Child Transmission (PMTCT) program in order to ensure that they are not run as parallel programs. Moreover, PMTCT and ARV programs need a high-level coordination forum to ensure that implementation bottle necks are addressed and program planning and training are well coordinated.

¶10. Child Health: Child health indicators showed steady improvements through the 1970's and 1980's; but since then, there has been a reversal in the trend. Between the 1991 and 2001 census, infant mortality rose from 48 to 56 per 1000 live births, and under-five mortality increased from 63 to 74 per 1000. Many believe this is mainly due to the HIV/AIDS pandemic, which accounts for nearly half of all under-five deaths. The remainder is due to diarrhea, acute respiratory infections, pneumonia and neonatal causes. Nonetheless, demographic projections indicate that the peak in infant and under five mortality rates should have declined to 28 and 58 per 1000 respectively in 2007 due to the roll out of ART and PMTCT.

¶11. Non-communicable Diseases: There are indications that non-communicable diseases are on the rise, notably cardiovascular diseases, hypertension, cancer, mental disorder and diabetes. While the data may be partially a result of improved diagnostic methods, it may also be attributable to lifestyle changes that are encouraging the growth of such diseases. The government needs to provide the population with health information on diet and exercise in order to encourage them to live healthy life styles. There is also a need to do further situation analysis of communicable disease to facilitate and inform program planning and response and determine the true burden to the country. The World Health Statistics 2008 indicates that leading infectious diseases like tuberculosis, HIV, neonatal infections and malaria will become less important causes of death globally over the next 20 years.

¶12. Death and injuries from car accidents also constitute a major problem for the health sector; they are largely due to driver error and alcohol abuse. According to the Central Statistical Office (CSO) statistical brief No 3/May, 2008, the number of road accidents rose from 65 per 10,000 in 1995 to 108 per 10,000 in 2003. It decreased to 106 per 10,000 2004, and further 98 per 10,000 population in 2006. Though there are signs of a drop in road accidents, they still need to fall them further.

Challenges

¶13. Given the aforementioned disease burden and other health infrastructure issues in Botswana, the health sector will continue to face major challenges in the foreseeable future. They include: a) the need to respond appropriately to the country's changing demographic profile. For instance, there is a need to look at task shifting to respond to new health areas such as a) consider male circumcision; b) prioritize disease programs, such as striking a balance between HIV and AIDS and other serious diseases; and c) ensure appropriate resource allocation between primary health care(PHC) and hospital-based services. There is clear need to place emphasis on PHC to avert the cost related to hospital care; d) harmonize the current range of health sector policies and strategies into an integrated health policy, and the development of a strategic plan to guide the implementation of health care in Botswana; d) improve the referral system and reduce distances and delays between primary, secondary and tertiary facilities; and e) develop a long-term, cost-sharing strategy.

¶14. At the service delivery level, the health sector also faces a shortage of manpower, and slow implementation of policies, strategies and programs. The availability and use of timely health information for policy and planning is equally weak across all health sectors and programs. Consequently, the effective implementation of policies formulated for various health programs is low and lacks proper monitoring and evaluations of outcomes and impacts. For instance, in a damning headline titled "Shortage of Medical Supplies Blights our Nation Reputation", the September 7 edition of the Sunday Standard detailed the lamentable situation of patients unable to access medical supplies due to shortages at public health centers. The author urged the President to use his powers to "ensure that Botswana's health system is saved from ...a slide towards eventual crumble." Nonetheless, the GOB and development partners are trying to respond to all these health challenges, with a special effort to strengthen Botswana's health infrastructure despite the difficulties posed by the HIV/AIDS epidemic and other development challenges.

¶15. Final Comment: Stronger linkages between the MOH and other line ministries, development partners and key stakeholders should seek to strengthen the health system response in order to achieve Botswana's Vision 2016 and the UN's Millennium Development Goals. Some have voiced concerns that HIV/AIDS programs, especially the provision of ART, have squeezed the resources available for other important health programs. This unease is not without foundation. In a July 23, 2008 health article on the Science and Development Network newsfeed (i.e., SciDEV.Net), the author asserts that "chronic diseases such as cancer, diabetes and heart disease are quickly overtaking infections as the biggest killers of the world's poor," and in fact kill a higher proportion of people than infectious diseases. In short, the author concludes, under-resourced health systems in developing countries must now cope with the twin burden of infectious and non-communicable diseases. However, most funding from donors is directed toward the former, with comparatively little going to the latter. The GOB would do well do take cognizance of this emerging reality.

GONZALES